Gloucestershire Hospitals
NHS Foundation Trust

TRUST POLICY

DEATH REVIEWS POLICY

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FAST FIND:

- **Action Cards MR1, MR2 and MR3**

1. INTRODUCTION / RATIONALE

This policy describes the approach at GHNHSFT to the review of patients dying in the Trust and within 30 days of discharge. This policy will bring the Trust in line with the national guidance contained within the document 'National Guidance on Learning from Deaths'.

2. DEFINITIONS

Death within the Trust includes all those from admission (including ED). Where relating to Summary Hospital Mortality Index, deaths attributable to the Trust include those up to 30 days post discharge. In addition those deaths of patients who continue in an episode of care started within the Hospitals Trust but after transfer to another provider (other acute trusts, community hospitals) or to normal place of residence/community/their home, will contribute to the Trust's overall mortality figures.

Word/Term	Descriptor
Hospital Standardised Mortality Ratios (HMSR) (include super spells)	The HSMR is a method of comparing mortality levels in different years or for different sub-populations in the same year, while taking account of differences in case mix. The ratio is of observed to expected deaths (multiplied conventionally by 100). Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. The HSMR is a calculation used to monitor death rates in a trust. The HSMR is based on a subset of diagnoses which give rise to around 80% of in-hospital deaths. HSMRs are based on the routinely collected administrative data often known as Hospital Episode Statistics (HES), Secondary Uses Service Data (SUS) or Commissioning Datasets (CDS). For all of the 56 diagnosis groups, the observed deaths are the numbers that have occurred following admission in each NHS Trust during the specified time period. The expected number of deaths in each analysis is the sum of the estimated risks of death for every patient.
Standardized Mortality Ratio (SMR)	This is a ratio between the observed number of deaths in a study population and the number of deaths that would be expected, based on the age- and sex- specific rates in a standard population and the age and sex distribution of the study population.
Summary Hospital-level Mortality Indictor (SHMI)	This is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England who either die while in hospital or within 30 days of discharge home. The expected number of deaths is calculated from statistical models derived to estimate the risk of mortality based on the characteristics of the patients (including the condition the patient is in hospital for, other underlying conditions the patient

	suffers from, age, gender and method of admission to hospital. A three-year dataset is used to create the statistical models. A one-year dataset is used to calculate the SHMI and accompanying contextual indicators for each trust.

3. POLICY STATEMENT

This Policy is to achieve compliance with national guidance on learning from deaths applicable to all staff engaged in such reviews.

4. ROLES AND RESPONSIBILITIES

Post/Group	Details
Hospital Mortality Group	The Hospital Mortality Group is responsible for the following main functions: 1. To review and monitor Trust data on mortality monthly and report to the Quality and Performance committee. 2. To ensure that there are governance processes in place with the Divisions to regularly monitor and review deaths within the Trust and to ensure that unexpected deaths are adequately audited and lessons learnt reported to the Quality and Performance committee. 3. To oversee the management and investigation of mortality alerts. 4. To distribute within the Trust any lessons learnt from mortality audits and investigations. 5. To oversee the contract with Dr Foster for the Intelligence Mortality Comparator and Quality Investigator. 6. To oversee linkages to End of Life Care programmes. 7. To ensure that other information on mortality is collated and reported as appropriate.
Speciality M&M lead	• To lead the process at a speciality level in line with this policy. • To ensure speciality processes are in line with the national mortality review process • To take responsibility for ensuring regular mortality meetings take place • To ensure data from these reviews is captured and communicated within the speciality • To ensure that actions from the mortality reviews are completed in line with their specified timescales • To ensure learning is recorded on the Trust database so that it can be reviewed at the HMG and transferable learning captured
Speciality Governance Group	• To receive and report the outcome(s) from mortality reviews to the Divisional Governance group
Divisional Governance Group	• To receive and track actions and learning from speciality mortality groups • To report these outcomes to the Trust Quality and Performance group on a quarterly basis
Quality and Performance Committee	• To receive an overarching report of mortality outcomes • To oversee the reports from divisions on mortality outcomes • To oversee the learning from mortality reviews and receive assurance that speciality and general learning points are embedded
Trust Board	• To receive assurance that mortality review process, in line with national guidance, is in place • To receive in the open session of the Board a summary of the learning from mortality reviews

5. MORTALITY REVIEW PROCESS

5.1 The mortality review process will be undertaken at a speciality level. The expectation is that each speciality will have a monthly M&M meeting although the number of deaths within a speciality may determine the frequency of these meetings. The process will be determined by the speciality but must comply with the national mortality review guidelines (ref. 9.2)

5.2 Mortality reviews triggered by a Dr Foster alert (CUSUM and Relative Risk outliers) will be assessed at a Trust level initially and then, where appropriate, by the relevant speciality(s).

5.3 The bereavement office will highlight to the speciality the case(s) to be reviewed on a monthly basis and will be responsible for ensuring that those cases that fall within the trigger list are highlighted to the M&M lead. The business intelligence unit will identify by speciality the deaths within the Trust on a rolling monthly basis. Specialities may choose to identify groups of patients

for mortality review on an ad hoc basis. Where this is an ongoing requirement it should be added as a Trust wide trigger with the approval of the HMG.

5.4 The meetings will be multidisciplinary and either review all deaths (paediatrics, obstetrics, deaths following elective procedures) or, where the number of deaths would preclude practical undertaking of this comprehensive review, the cases as defined from the trigger list (Action Card MR1) plus a sample of other cases to be determined within the speciality.

5.5 Conclusions from the mortality reviews contained within the RCP Structured Judgement Review process will be agreed by the M&M group and recorded. Where appropriate these should be converted into a series of actions aimed at learning from these mortality reviews and designed to improve patient care. These actions must have an identified lead, appropriate timescales and measureable outcomes.

5.6 The group will also consider if any of the reviews meet the threshold for triggering an incident report and the Duty of Candour process.

5.7 The actions will be reviewed and monitored at the Speciality M&M meeting to ensure closure within an appropriate timescale or understand what is preventing progress of actions and identify clear responsibility for making progress.

5.8 The output from these meetings will be recorded on the Trust mortality database which should be updated at each M&M meeting.

5.9 Learning from each review must be recorded and general learning themes should be included in this database, which will be reviewed at Divisional level and Trust level.

5.10 There should be a clearly defined communication cascade within the speciality for disseminating the learning from this review throughout the speciality. The Emergency Department has an example of good practice in this respect.

5.11 Mortality reviews initiated as a result of an SI will be processed by RCA and shared with the speciality. On completion the findings will be recorded in the Trust database.

5.12 Families should be engaged with mortality reviews where appropriate. This involvement must follow the guidance contained in National Guidance on Learning from Deaths (ref 9.2) and include informing the scope of reviews and receiving the outcomes.

5.13 Please see the Death Review Flowchart

6. OUTCOMES

6.1 The outcomes from mortality reviews will be recorded by the speciality as defined above. These will be reviewed through the content of the speciality database at the divisional board on a monthly (or suitable) interval.

6.2 The Divisional Board will assure the process is in place by speciality, that the appropriate cases are being reviewed and that timely completion of the action plans are in place. The Divisional Board will also ensure that when generalizable learning for the division is identified, this is communicated and actioned as appropriate.

7. TRAINING

7.1 All those involved in mortality reviews will undertake the Trust training on Structured Judgement Reviews. This is in line with national recommendations and will be in the form of an e-learning micro-teach.

8. MONITORING OF COMPLIANCE

Do the systems or processes in this document have to be monitored in line with national, regional or Trust requirements?	NO

8.1 The Divisional Board will include in its quarterly report to the Quality and Performance Committee a summary of these reviews and learning.

8.2 The Division will also assure itself that where appropriate Duty of Candour policy is followed.

8.3 The Quality and Performance Committee will review these outcomes on a monthly basis and develop appropriate reporting to the Trust main board. It will assure itself that all appropriate processes are in place.

9. REFERENCES

9.1 Learning, candour and accountability https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

9.2 National Guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

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RELATED TRUST DOCUMENTS	Action Cards MR1, MR2 and MR3
OTHER RELEVANT DOCUMENTS	Care of the Dying and Deceased Action card A0030 CDD1 - Reportable Deaths Safeguarding Children Policy SCH7 Child death review procedure
EXTERNAL COMPLIANCE STANDARDS AND/OR LEGISLATION	National Guidance on Learning from Deaths: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf